STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155446	B. WIN			07/19/	/2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			/ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	TER		WAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	l		F00	100			
		or the investigation of	F00	000			
	Complaint IN00	0111127.					
	Complaint INOO	0111127-Substantiated,					
	_	eficiencies related to the					
		eited at F 279, F 282,					
	F323, and F 513	3.					
	Survey dates: 7/	717, 18, 19, 2012					
	Facility number	: 000476					
	Provider numbe						
	Aim number: 10						
		, o = , o = , o					
	Survey team:						
	Ann Armey, RN	N TC					
	Ellen Ruppel, R	N					
	Census bed type	e:					
	SNF/NF: 125						
	Total: 125						
	Census payor ty	rpe:					
	Medicare: 21						
	Medicaid: 73						
	Other: 31						
	Total: 125						
	Sample: 8						
	Those deficient	ios raflact stata findir					
		ies reflect state findings					
	cited in accorda	nce with 410 IAC 16.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000476

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/16/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  COVINGTON MANOR HEALTH AND REHABILITATION CENTER  (X4) ID  PREFIX  TAG  Quality review completed 7/24/12  Cathy Emswiller RN  STREET ADDRESS, CITY, STATE, ZIP CODE  5700 WILKIE DR  FORT WAYNE, IN 46804  (X5)  PREFIX  PREFIX  TAG  PROVIDERS PLAN OF CORRECTION (EACH OERICCITIC ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE  (X5)  COMPLETION DATE	AND PLAN OF CO		DENTIFICATION NUMBER:  155446	A. BUILI B. WING	DING	00	COMPLETED 07/19/2012	
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Quality review completed 7/24/12    Completion of the appropriate Deficiency			TH AND REHABILITATION CENT	ER	5700 W	ILKIE DR		
	PREFIX	(EACH DEFICIENC	Y MUST BE PERCEDED BY FULL	I	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155446	A. BUIL B. WING			07/19/	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279 SS=D	483.20(d), 483.2 DEVELOP COM PLANS A facility must us assessment to de resident's compre The facility must care plan for each measurable obje meet a resident's mental and psychidentified in the compre The care plan measurable obje meet a resident's mental and psychidentified in the compre The care plan measurable obje mental and psychidentified in the compre sident's highes mental, and psychidentified under § that would other §483.25 but are resident's exercis including the right §483.10(b)(4). Based on observations	prediction of the set the results of the evelop, review and revise the ehensive plan of care.  develop a comprehensive the resident that includes ctives and timetables to a medical, nursing, and thosocial needs that are comprehensive assessment.  Just describe the services that the dot attain or maintain the att practicable physical, chosocial well-being as 483.25; and any services wise be required under not provided due to the se of rights under §483.10, at to refuse treatment under	F02		A Smoking Safety Assessmen and a Smoking Risk Care Plar		08/18/2012
	develop a care pl	e facility failed to an to address smoking iciency affected 1 of 3			was completed on 7/16/12 for Resident E. While developing plan of care for Resident E, it v	the	
	residents reviewe	ed, who smoked at the			determined that Resident E wo		
	facility, in a same	ple of 8. (Resident #E)			need a smoking apron to facilit	tate	
	Findings include On 7/17/12 at 9:1				safe smoking. The smoking apron arrived on 7/18/2012 from a sister facility. Resident E is part of Safe Smoking Program were oxygen use is prohibited, adaptive equipment is monitored, and supervision is provided		
	indicated there ha	ad been an incident on			during the smoking periods.		
	7/15/12 and Resi	dent #E had been burned			All residents identified with the	!	
		e smoking in an outdoor			desire to smoke had the Smok Safety Assessment(Attachme	-	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155446	B. WIN		·	07/19/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ILKIE DR		
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEN	TER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	smoking area.				A) and Smoking Risk Care Pla		
	The Administrat	or indicated the incident			(Attachment B) reevaluated. A	Ą	
	was not witnesse	ed by facility staff but had			formal letter was sent to all		
		ter to facility staff by a			resident representatives, to		
	_	tnessed the incident. The			educate them on the important of not providing smoking matri		
	•				directly to the resident	ais	
		dicated, after the			(Attachment C). Every smoke	r	
	· ·	dent who smoke, were			will follow the Safe Smoking		
		neir care plans were			Guidelines and sign a Release	;	
	reviewed. The A	dministrator indicated the			and Disclosure of Smoking Ris	sks	
	smoking policy	was revised, a schedule of			(Attachment D).	_	
	designated smok	ring times was initiated,			The facility put into place a Sa		
	residents were ed	ducated regarding the			Smoking Program. All resident must be accompanied by the	IS	
		oking materials with			designated staff member during	ıa	
	_	staff and residents were			the scheduled smoking times.	9	
	_				The smoking times occur ever	V	
	now monitored (	during smoking sessions.			two hours from the hours of	•	
					9:00am to 9:00pm. In addition,		
		30 a.m., Resident #E was			the staff member responsible f		
	observed in her	wheelchair in her room.			monitoring the residents, must		
	Her left hand wa	s bandaged and she was			complete the Smoking Check-		
	asked about the	injury to the hand. The			(Attachment E) In-servicing w provided to all staff members	as	
		d it happened just like			regarding the changes with		
		oped her finger. Resident			resident smoking (Attachment	t	
	_	could not reach the			<b>F</b> ).		
		control that was on the			The Smoking Check-Off will be	Э	
	1				given to the Director of Nursing	•	
		elchair, so after the spark,			for review. All Smoking Safety		
	1 -	asal canula tubing so it			Assessments and Smoking Ri		
		l to the oxygen tank. The			Care Plans will be reviewed by the Interdisciplinary Team on a		
	resident indicate	d she smoked			quarterly, annual and significa		
	independently ar	nd it was usual for her to			change basis. A resident with		
	have her oxygen	with her when she went			preference of smoking, will be		
	out to smoke. Sh	e indicated she would			maintained on an auditing		
	take the nasal ca	nula off and hang it on			spreadsheet to ensure the		
	take the nasal canula off and hang it on the wheelchair while she was smoking.				assessments are completed in		
	die wheelenan w	mic she was smoking.			timely manner (Attachment G	).	
					The Director of Nursing will		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CO ILDING	ONSTRUCTION 00	(X3) DATE COMPI	LETED
		155446	B. WII			07/19	/2012
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	TER	5700 W	ADDRESS, CITY, STATE, ZIP CODE ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	witnessed and re interviewed. The Resident #E had lap and there was said she told Restubing on the gropatted the flame the tubing out of On 7/18/12 at 1:3 worked on Resid interviewed. She went out with he LPN indicated R not to do this but independently ar so it was difficul	rd of Resident #E was			maintain this spreadsheet. In addition, any discrepencies f within the Smoking Check-O and Smoking Assessmen Auspreadsheet will have immed corrective action and discuss the monthly QA&A meeting t further identify any changes needed to the program.	ound ff idit diate sed at	
	indicated the resi facility on 4/16/1 included and wer	7/12 at 1:50 p.m. and ident was admitted to the 2, with diagnoses which re not limited to, chronic onary disease and					
	dated 4/16/12, in not desire to smo additional assess						
	Physician orders	, dated 4/21/12, indicated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446			MULTIPLE CO ILDING NG	NSTRUCTION 00	COMP	E SURVEY LETED 9/2012		
	PROVIDER OR SUPPLIER	LTH AND REHABILITATION CEI	STREET ADDRESS, CITY, STATE, ZIP CODE  5700 WILKIE DR  FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	(X5) COMPLETION DATE		
		to receive oxygen at 3 anula continuously.						
	resident had no c required supervis transfer/locomot extensive assista	ed 6/14/12, indicated the cognitive impairments, sion of one staff for ion/toileting, required nce with dressing and during the 7-day						
	indicated "has 1s of hand. Redness discomfort. Area Bacitrin (sic) & Res (resident) re happened; peers outside smoking portable O2 tank has been told mu (and) aides to tak outside to smoke	et:30 a.m., nursing notes st degree burn to left palm sonoted. Denies pain or a cooled w/cold water; (and) bandage applied. fused to state what report that res (resident) at (with) O2 (oxygen) at Res (Resident) altiple times by nurses & the tank off before going at (Physician's Name) at own POA (Power of						
	indicated Reside	1:10 p.m., nursing notes nt #E's left hand was p.m. and she had four rs.						
		30 p.m. nursing notes ident had four fluid filled						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			MULTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE S	ETED
		155446	B. WI	NG		07/19/	2012
	PROVIDER OR SUPPLIEF	LTH AND REHABILITATION CEI	NTER	5700 W	ADDRESS, CITY, STATE, ZIP CODE ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ТЕ	(X5) COMPLETION DATE
	blisters to palm/s blister to the createst hand measure 1.8 cm by 1.4 cm 0.9 cm by 0.8 cm 1.1 cm by 0.5 cm 1.5 cm by 1.3 cm 1.7 cm by 1.8 cm  There was no do safety care plants the incident, on a  The Smoking Sa 7/16/12, indicates potentially unsafe supervised and we non-flammable of when smoking."  The Smoking Ri 7/16/12, indicates educate/enforce areas only, review smoking provide informations desired,	fingers and an open ase of the thumb on the ring as follows:  a;  a;  a;  a;  a;  a;  a;  a;  a;  a					
	supervised smok	-					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155446			MULTIPLE CO ILDING NG	NSTRUCTION  00	(X3) DATE COMPL 07/19/	ETED		
	PROVIDER OR SUPPLIER  STON MANOR HEALTH AND REHABILITATION CEN	TER	STREET ADDRESS, CITY, STATE, ZIP CODE  5700 WILKIE DR  FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	Although the assessment indicated the resident must wear a smoking apron, there was no mention of the apron in the care plan.							
	Resident #E was observed during smoking sessions on 7/17/12 at 11:00 a.m., at 7/17/12 at 3:00 p.m. and 7/18/12 at 9:00 a.m. Resident #E was being monitored by staff, the oxygen was removed prior to smoking, and smoking material were provided by staff. The outside smoking area had a fire extinguisher, a water thermos, and a safety ash receptacle. Resident #E did not wear an apron during the smoking sessions observed.  On 7/17/12 at 4:00 p.m., the Administrator indicated they were unable to locate a smoking assessment or a smoking care plan for the resident prior to the incident.  On 7/18/12 at 11:00 a.m., the Administrator indicated and smoking aprons had been ordered on 7/16/12 but had not yet been delivered, smoking aprons were being obtained from a sister facility and would be delivered on 7/18/12.  The Smoking Policy, revised October							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155446		LDING	NSTRUCTION  00	(X3) DATE COMPL <b>07/19</b> /	ETED	
	PROVIDER OR SUPPLIER	.TH AND REHABILITATION CEI	STREET A	ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	incident on 7/15/administrator, wa 2:00 p.m. and incidents for safet smoking The Irr (IDT) is responsively residents for safet smoking The Irr (IDT) is responsively acconducted in a safet admission, with a change and annexpress a desire admission, with a change and a c	o monitor and evaluate ety related to sterdisciplinary Team able for ensuring safety ed, and that smoking is afe manner evaluate safety, physical essues, and the need for ey equipment upon every significant mually for resident's who to smoke. rol distribution of all enting materials for all				

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	
		155446	B. WIN			07/19/	/2012
NAME OF P	PROVIDER OR SUPPLIER	<del>.</del> R			ADDRESS, CITY, STATE, ZIP CODE	-	
					ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	TER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	smoking						
		to monitor and prevent					
	complications."						
		relates to Complaint					
	IN00111127.						
	3.1-35(b)(1)						
							1

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155446	B. WIN			07/19/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ΓER		WAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY COARE PLAN The services profacility must be profacility m	45 a.m., during the R (Medical Records) I indicated Resident #D	F02	TAG 82	A meeting was held to reeducathe nurses on the double check system in place to identifying completion of all treatments. From the nurse's meeting note "During shift change the out-goand in-coming nurses must review the MAR/TAR for any holes indicating the potential for incomplete treatments". A mee was held to reeducate the nurse on the double check system in place to identifying completion all treatments. From the nurse meeting notes, "During shift change the out-going and in coming nurses must review."	k es, ping or ting ses of 's	08/18/2012
	The clinical recoreviewed on 7/17 indicated the resifacility on 2/7/12 included but wer vascular accident weakness and insmellitus.  The MDS (Minin Assessment, date Resident #D had	ed 5/16/12, indicated		in-coming nurses must review MAR/TAR for any holes indicated the potential for incomplete treatments". At shift changet, the incoming and outgoing nurse review the MAR/TAR for any missed signature indicating the treatment was not completed. The incoming and outing nurse must both sign the Verification Review of MAR/TAR During Section Change document indicating the process was completed (Attachment H). The Unit Manager will review the document daily and discuss a defiecencies in the daily Clincol Meeting. In addition, the Verification of Review of		ting ne will e of hift nis	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED
		155446	B. WIN			07/19/2012
			В. W II V		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		VAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	assistance with to	ransfer, dressing and			MAR/TAR During Shift Change	
	hygiene.				completed verification docume	
					will be forwarded to the Director	
	On 6/19/12, a Pressure Evaluation Record				of Nursing weekly for review and filing. If signatures are missed,	
	· ·	eas were identified on			indicating the review was not	
		ft heel, measuring 4.8 cm			completed, both the incoming	and
		her left great toe,			outgoing nurse will be held	
	~	n by 2.2 cm. The record			responsible for any error.  Corrective action and reeduca	tion
	_	f the areas as UTD			will result, e nforced by the Un	
		mine/Unstageable) and			Manager and/or Director of	
	`	heel wound bed was			Nursing. Results will be submi	
					to the QA committee monthly f	
		% slough while the left			at least three moonths for review	ew
	_	bed was covered with 50			and recommendations; this monitoring will continue until n	0
	% slough.				issues are identified for a three	
					month period.	
	On 6/19/12, the I	Physician was notified			·	
	and the following	g was ordered:				
	Santyl/Bactrobar	n mix to left heel twice				
	daily and cover v	with a clean dry dressing;				
	Bactroban to the	left great toe and cover				
	with clean dry dr	ressing every day;				
		antibiotic medication)				
	100 mg twice da	-				
	Vitamin C 500 m					
	Zinc Sulfate 220	• • • •				
		Count, Albumin, and				
	_	oratory tests; and				
		ound of the left lower				
	* *	ound of the left lower				
	leg.					
	On 6/21/12, the r	resident was examined by				
	· ·	ician. The Wound Care				
	1	t indicated a third				
		was noted on the right				
	unstageable alea	was noted on the right				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155446	B. WIN			07/19/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	heel, measuring :	5.0 cm by 4.5 cm.				
	On 6/21/12, the I	Physician ordered				
	Crowfoots and a	bilateral lower leg				
	arterial Doppler	ultrasound. The				
		changed to cleanse the				
		eel, and left toe with				
		oply skin prep topically				
		dry dressing every day.				
	and cover with a	dry dressing every day.				
	On 6/28/12, the f	frequency of the				
		left heel, left toe, and				
	_	ncreased to twice daily by				
	the Wound Physi	ician.				
	On 7/6/12, physi	cian's orders indicated				
	the treatment to t	the left heel was changed				
	to Santyl/Bactrol	oan mix and cover with				
	foam every day.					
		right heel and left toe				
		(cleanse with normal				
		skin prep with a clean				
	dry dressing twice					
	On 7/12/12 the V	Wound Care Specialist				
	· ·	ated the areas on the left				
		el were improving.				
		or word improving.				
	On 7/18/12 at 2:0	00 p.m., the wounds on				
		et were observed. The				
	Wound Nurse. m	neasured the wounds and				
	found them to be					
		by 6 cm., covered with				
		at was pulling away from				
	an eschai cap illa	n was pulling away nom	1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			07/19/2012
NAME OF B	NOTABLE OF CLIBBLIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	TER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)	DATE
	the edges of the	· ·				
	right heel, 2.8 ci	•				
	· ·	y 1.2 cm The areas on				
	_	l left toe were dry and				
	healing.					
	On 7/18/12 at 2:	15 p.m., Resident #D was				
	interviewed. She	indicated the facility				
	provided her wit	h a specialized air loss				
	mattress but she	did not like the				
	movement of the	mattress and asked that				
	it be removed. Sl	he indicated she did not				
	like to wear her s	specialized boots and				
		ced under her lower legs				
	when she was in	· ·				
		her indicated that her				
		be done twice daily but				
		•				
	was not aiways c	lone on the evening shift.				
		cumentation, on the July				
	2012 MAR (Med	dication Administration				
	Record), that the	twice daily treatment				
	was done in the	evening on three of				
	sixteen days (7/9	,11,12/12).				
	On 7/9/12 and 7/	12/12 there were blanks				
	in the area where	the evening treatment				
	should have bee	n documented and on				
	7/11/12 the treat	ment was circled as not				
	done, with no ex					
	On 7/19/12 -4 2:	10 m ma tha ADON				
		10 p.m., the ADON				
		s not able to determine if				
	_	ments on 7/9/12/12,				
	7/11/12 and 7/12	/12 were done.				

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	OF CORRECTION	IDENTIFICATION NUMBER:  155446	1	LDING	00	COMPL 07/19/	ETED		
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	TER	STREET ADDRESS, CITY, STATE, ZIP CODE  5700 WILKIE DR  FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE		
	dated 2006, prov Administrator, w and indicated, in ulcer is present, responsible to re skin,as well as provided"	vas reviewed on 7/19/12, part, "If a pressure the licensed nurse is cord the condition of the							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155446	B. WIN	G		07/19/	2012
NAME OF P	ROVIDER OR SUPPLIER	·			ADDRESS, CITY, STATE, ZIP CODE		
					VILKIE DR		
COVING	TON MANOR HEAL	LTH AND REHABILITATION CEN	TER FORT		WAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
F0323	483.25(h)	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCT)		DATE
SS=G	FREE OF ACCI	DENT					
00-0	HAZARDS/SUPERVISION/DEVICES						
		ensure that the resident					
		nains as free of accident					
	· ·	ssible; and each resident					
		ate supervision and ses to prevent accidents.					
		ation, interview, and	F03	23	A Smoking Safety Assessmer		08/18/2012
		ne facility failed to ensure			and a Smoking Risk Care Plan		
	· ·	sident, who was smoking			was completed on 7/16/12 for Resident E. While developing the		
	<u> </u>	oking area and failed to		plan of care for Resident E, it was determined that Resident E would			
	prevent oxygen ı	usage in a smoking area.					
		a resident being burned.			need a smoking apron to facilitate		
		affected 1 of 3 residents			safe smoking. The smoking	apron arrived on 7/18/2012 from	
	1	moked at the facility, in a			a sister facility. Resident E is		
	sample of 8. (Re	•			of Safe Smoking Program wei		
	1	,			oxygen use is prohibited,		
	Findings include	:			adaptive equipment is monitor	red,	
					and supervision is provided during the smoking periods.		
	On 7/17/12 at 9:	15 a.m., during the			All residents identified with the	9	
	entrance confere	nce, the Administrator			desire to smoke had the Smol	•	
		ad been an incident on			Safety Assessment(Attachme		
	7/15/12 and Resi	ident #E had been burned			A) and Smoking Risk Care Pla (Attachment B) reevaluated.		
		e smoking in an outdoor			formal letter was sent to all	^	
	smoking area.				resident representatives, to		
	_	or indicated the incident			educate them on the importan		
		nessed by facility staff			of not providing smoking matr	ials	
		orted later to facility staff			directly to the resident (Attachment C). Every smoke	or.	
	•	ad witnessed the incident.			will follow the Safe Smoking	;ı	
		or indicated, after the			Guidelines and sign a Release	е	
		· · · · · · · · · · · · · · · · · · ·			and Disclosure of Smoking Ri		
	•	dent who smoke, were			(Attachment D).	_	
		neir care plans were			The facility put into place a Sa		
		dministrator indicated the			Smoking Program. All residen must be accompanied by the	ເຮ	
	smoking policy v	was revised, a schedule of			designated staff member during	ng	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLET	ED
		155446	A. BUII			07/19/20	012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
00,4,10		TIL AND DELIABILITATION OF 15			ILKIE DR		
COVING	ION MANOR HEAL	TH AND REHABILITATION CENT	IER	FORTV	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	designated smok	ing times was initiated,			the scheduled smoking times.		
residents were educated regarding the				The smoking times occur ever	у		
		oking materials with			two hours from the hours of		
	•				9:00am to 9:00pm. In addition		
	_	staff and residents were			the staff member responsible t		
	now monitored d	luring smoking sessions.			monitoring the residents, must		
					complete the Smoking Check- (Attachment E) In-servicing w		
	On 7/17/12 at 9:3	30 a.m., Resident #E was			provided to all staff members	45	
	observed in her v	wheelchair in her room.			regarding the changes with		
	Her left hand wa	s bandaged and she was			resident smoking (Attachmen	t	
		njury to the hand. The			F).		
		d it happened just like			The Smoking Check-Off will be		
					given to the Director of Nursing		
		pped her finger. Resident			for review. All Smoking Safety		
		could not reach the			Assessments and Smoking Ri		
	portable oxygen	control that was on the			Care Plans will be reviewed by		
	back of her whee	elchair, so after the spark,			the Interdisciplinary Team on a quarterly, annual and significa		
	she yanked the n	asal canula tubing so it			change basis. A resident with		
		to the oxygen tank. The			preference of smoking, will be		
	resident indicate				maintained on an auditing		
		nd it was usual for her to			spreadsheet to ensure the		
					assessments are completed ir	ı a	
		with her when she went			timely manner (Attachment G	).	
		e indicated she would			The Director of Nursing will		
	take the nasal car	nula off and hang it on			maintain this spreadsheet. In		
	the wheelchair w	hile she was smoking.			addition, any discrepencies for	und	
					within the Smoking Check-Off and Smoking Assessmen Aud	i+	
	On 7/17/12 at 4:4	45 p.m., Resident #J, who			spreadsheet will have immedia		
		ported the incident, was			corrective action and discusse		
		resident indicated			the monthly QA&A meeting to		
					further identify any changes		
		her oxygen tubing in her			needed to the program.		
	•	s a flame. Resident #J					
	said she told Resident #E to throw the						
	tubing on the gro	ound but Resident #E					
	patted the flame	with her hand and jerked					
	-	the oxygen container.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155446	B. WIN			07/19/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L			ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		30 p.m. LPN #11, who				
	worked on Resid	lent #E's hall was				
	interviewed. She	indicated Resident #E				
	went out with he	r oxygen to smoke. The				
		he resident had been told				
	not to do this but					
		nd had her own supplies				
	so it was difficul					
	55 it was airrical	to monitor not.				
	The clinical reco	rd of Resident #E was				
		7/12 at 1:50 p.m. and				
		ident was admitted to the				
		2, with diagnoses which				
		re not limited to, chronic				
	obstructive pulm	onary disease and				
	schizophrenia.					
	The Admission N	Nursing Assessment,				
		dicated the resident did				
	· ·	oke and as a result no				
	additional assess					
	Physician orders	, dated 4/21/12, indicated				
	the resident was	to receive oxygen at 3				
	liters per nasal ca	anula continuously.				
	_	•				
	The MDS (Minii	mum Data Set)				
	Assessment, date	ed 6/14/12, indicated the				
		cognitive impairments,				
		sion of one staff for				
		ion/toileting, required				
		nce with dressing and				
		C				
	aid not ambulate	during the 7-day				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155446	B. WIN			07/19/	2012
			В. W II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ILKIE DR		
COVING.	TON MANOR HEA	LTH AND REHABILITATION CEN	TER		VAYNE, IN 46804		
(VA) ID	CHMMADVC	TATEMENT OF DEFICIENCIES	1	ID	,		(7/5)
(X4) ID PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710	observation perio	*		1110			BATTE
	observation perio	od.					
	0 7/15/10 + 10	. 20					
		0:30 a.m., nursing notes					
		st degree burn to left palm					
		s noted. Denies pain or					
		a cooled w/cold water;					
		(and) bandage applied.					
	` ′	fused to state what					
	happened; peers	report that res (resident)					
	outside smoking	c (with) O2 (oxygen)					
	portable O2 tank	. Res (Resident)					
	has been told mu	ıltiple times by nurses &					
	(and) aides to tal	ke tank off before going					
	outside to smoke	e. (Physician's Name)					
		nt own POA (Power of					
	Attorney).						
	110011107).						
	On 7/15/12 at 10	0:10 p.m., nursing notes					
		nt #E's left hand was					
		p.m. and she had four					
	fluid filled bliste						
	India illica biiste	13.					
	On 7/16/12 of 2:	30 p.m. nursing notes					
		ident had four fluid filled					
		fingers and an open					
		ase of the thumb on the					
	left hand measur	<del>-</del>					
	1.8 cm by 1.4 cm						
	0.9 cm by 0.8 cn						
	1.1 cm by 0.5 cn						
	1.5 cm by 1.3 cn						
	1.7 cm by 1.8 cn	n					
	There was no do	cumentation a smoking					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN	IG		07/19/2012
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			5700 W	ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEI	NTER	FORT V	VAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1	t or smoking care plan				
		until, after the incident,				
	on 7/16/12.					
	The Smoking Sa					
	_	16/12, indicated the				
	_	otentially unsafe smoker				
	_	pervised and wear a				
	protective non-fl	ammable cover (smoking				
	apron) when smo	oking."				
	The Smoking Ri	sk Care plan, dated				
	7/16/12, indicate	d the following:				
	educate/enforce	smoking in designated				
	areas only,					
	review smoking	safety quarterly,				
	provide informat	ion on smoking cessation				
	as desired,					
	provide safe rece	eptacles for extinguishing				
	ashes,					
	reinforce safe pra	actices,				
	praise safe practi	ices,				
	staff to retain cig	garettes,				
	staff to retain lig	hters, and				
	supervised smok	ing.				
	Although the Sm	oking Safety Assessment				
	indicated the res	ident must wear a				
	smoking apron, t	there was no mention of				
	the apron in the					
		observed during				
		s on 7/17/12 at 11:00				
	a.m., at 7/17/12 a	at 3:00 p.m. and 7/18/12				
	at 9:00 a.m.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE : COMPL		
		155446	A. BUI B. WIN	LDING		07/19/	
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	t .			ILKIE DR		
COVING	TON MANOR HEAL	LTH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		unitored, the oxygen		TAG	DEFICIENCE!)		DATE
		or to smoking, and					
	_	l were provided by staff.					
		king area had a fire					
		vater thermos, and a					
	safety ash recept						
	Resident #E did	not wear an apron during					
	the smoking sess	sions observed.					
	On 7/17/12 at 4:0	_					
		dicated they were unable					
to locate a smoking assessment or a		_					
	the incident.	an for the resident prior to					
	the incident.						
	On 7/18/12 at 11	:00 a.m., the					
		dicated and smoking					
	aprons had been	ordered on 7/16/12 but					
	had not yet been	delivered, smoking					
	aprons were beir	ng obtained from a sister					
	· ·	ld be delivered on					
	7/18/12.						
	The Smoking Do	licy, revised October					
		place prior to the					
	•	12, provided by the					
		as reviewed on 7/17/12 at					
	2:00 p.m. and inc						
	_	o monitor and evaluate					
	residents for safe						
		nterdisciplinary Team					
	(IDT) is responsi	ible for ensuring safety					
		ed, and that smoking is					
	conducted in a sa	afe manner					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED 07/19/2012		
		155446	B. WIN			07/19/	ZUTZ
NAME OF F	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
COMMO	TON MANOD HEAD	LTH AND REHABILITATION CEN	ITED		ILKIE DR VAYNE, IN 46804		
				<u> </u>	VAINE, IIN 40004	1	ave.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		evaluate safety, physical					
		ssues, and the need for					
		y equipment upon					
	admission, with						
		nually for resident's who					
	express a desire						
	2. Staff will cont	trol distribution of all					
	cigarettes and lig	ghting materials for all					
	residents,						
	3. For residents v	who have been					
	determined to ne	eed supervised smoking,					
	or are unsafe wh	en smoking, staff will					
	provide appropri	ate supervision					
	a. Use of adaptiv	ve equipment (smoking					
	aprons, etc.)						
	5. Portable oxyg	en tanks and/or other O2					
		are not allowed in					
	designated smok is turned off.	ing areas, even if oxygen					
	6. Residents who	o do not adhere to facility					
	smoking protoco	ols and rules should be					
	reviewed for alte	ernate placement					
		mentation Guidelines					
		able goals for safe					
	smoking						
		to monitor and prevent					
	complications."						
	This Federal tag	relates to Complaint					
	IN00111127.						
	3.1-45(a)(1)						
	3.1-45(a)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED 07/19/2012		
		155446	B. WING		07/19/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
COMPG.	TON MANOR HEAD	LTH AND REHABILITATION CENT		/ILKIE DR WAYNE, IN 46804	
				T T T T T T T T T T T T T T T T T T T	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE	
1710	REGGEATORT OR	CESC IDENTIFICATION OR MICHIGAN	ing		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		155446	B. WIN		<del></del>	07/19/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				/ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0513 SS=D	RECORD-SIGN/ The facility must record signed an other diagnostic Based on intervie	file in the resident's clinical dated reports of x-ray and	F05	F0513 The arterial and venous Dopultrasound was obtain eddurent the survey process for the cl		g	08/18/2012
	and arterial dopp	ler ultra sound reports in			record.The third shift nurse on		
	1	d. This deficiency			each unit will be responsible to		
		esidents whose ultrasound			all labs and diagnostic test for		
		ewed, in a sample of 8.			day by reviewing the TAR and		
	(Resident #D)	ewed, in a sample of o.			placing the tests on the form,		
	(Resident #D)				"Daily Lab and Diagnostic Tests Audit" (Attachment I). The floor nurse will utilize the form to ensure all labs and/or diagnostic		
	Findings include	:					
	On 7/17/12 at 9:4	45 a.m., during the			test results have been obtained in addition, the floor nurse will	u.	
	entrance tour, M	R (Medical Records)			ensure all follow through with t	:he	
	Staff Person #10	) indicated Resident #D			ordering physician has been		
	had bilateral pres	ssure areas on her heels.			completed. The Unit Manager review the "Daily Lab and	will	
	indicated the resi facility on 2/7/12 including but not vascular accident weakness and ins mellitus.	t limited to, cerebral t (stroke) with left sided sulin dependent diabetes			Diagnostic Test Audit" to spot check all components were completed. The form will be reviewed during the daily Clinic Meeting to identify and discuss any discrepancies. The completed form will be filed on the unit. The Unit Manager will review the document daily and discuss any deficiencies in the daily Clinical Meeting. Correcti		
	indicated two unidentified on the measuring 4.8 cm	essure Evaluation Record stageable areas were Resident #D's left heel, n by 4.6 cm and on her easuring 2.4 cm by 2.2			action and reeducation will res enforced by the Unit Manager and/or Director of Nursing. Discrepencies will be reviewed during the QA&A meeting to identify any further changes needed.Results will be submitted.	ult,	

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:  155446	A. BUII	BUILDING WING		COMPLETED 07/19/2012			
NAME OF PROVIDER OR SUPPLIER  COVINGTON MANOR HEALTH AND REHABILITATION CENT				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)		Ē	(X5) COMPLETION DATE		
	On 6/19/12, the F Venous Doppler left lower extrem On 6/21/12, the r the Wound Physis Specialist Report unstageable area heel, measuring 5 On 6/21/12, the F Arterial Doppler Resident #D's bil There was no docultrasound studie On 7/18/12 at 6:0 reports, complete 6/22/12 were faxed On 7/18/12 at 1:1 (Assistant Director the arterial and versioned and reports we record until 7/18/	Physician ordered a ultrasound study of the ity.  esident was examined by cian. The Wound Care indicated a third was noted on the right 5.0 cm by 4.5 cm.  Physician ordered ultrasound studies of ateral lower legs.  cumentation the swere done.  99 a.m., the ultrasound ed on 6/20/12 and ed to the facility.  1.5 p.m., the ADON or of Nursing) indicated enous doppler ultra re not in the clinical			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	or ew			
	3.1-49(j)(4)								

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		ILDING	NSTRUCTION 00	COM	TE SURVEY  TPLETED  19/2012			
NAME OF PROVIDER OR SUPPLIER  COVINGTON MANOR HEALTH AND REHABILITATION CENTER										
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE			

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